Ontario Ministry of Health

Annual Report 1985/86

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Everyone has a share in the future of health care

87-02661/

Edith Gray and Robert Hicks

Ontario

To His Honour
The Lieutenant-Governor
of the Province of Ontario

May it please your honour:

It is my pleasure to present the sixty-first annual report of the Ministry of Health for the twelve-month period ending March 31, 1986, and the report of the Ontario Health Insurance Plan, as required under the Health Insurance Act.

Respectfully submitted,

Murray J. Elston

Murray J. Elston
Minister

Message from the Minister

Health care in Ontario is a vast enterprise; the province spent more than $27 million each day on health care services for 1985/86, absorbing about one-third of the entire provincial budget. But our health care system is also a public enterprise, belonging to the people of this province and existing solely to provide them with the care they need. The Ministry of Health manages this system but it does not own it. Instead, my ministry acts as a trustee for the public, with its principal function to ensure that the health care system serves the people.

This idea of trusteeship is the basis for our principal initiatives in 1985/86, which were primarily directed at improving accessibility to our health care system. We want to ensure that every resident of Ontario, in all regions, can obtain necessary health care and that obstacles to the provision of health care are removed.

These obstacles to health care may be financial. To that end, we passed the Health Care Accessibility Act, ending the practice of extra-billing and thus ensuring that patients will not avoid seeking care for financial reasons.

We also expanded the financial assistance available to young people who need special equipment or medical devices by extending eligibility to include persons up to 22 years old. This program provided more than $8 million in assistance during the year. As well, we added new benefits to cover the cost of corrective dental treatment for children suffering from cleft lip or cleft palate.

In addition, we have provided $5 million for the establishment of five regional geriatric units and directed $500,000 to community health centres to develop programs specifically oriented to the elderly.

Some barriers to care may be institutional – the lack of adequate facilities. The $850 million capital funding program for public hospitals, starting with $200 million for the rebuilding of the famed Princess Margaret Hospital and three regional cancer clinics, is a program that will improve and expand our hospital system. We are making this commitment so that our Ontario hospitals will be ready to meet the needs of people into the 21st century.

Another example of our commitment is the major re-development of The Hospital for Sick Children currently underway with ministry funding of $72.5 million.

In addition to providing new hospitals, we have also made our community programs more responsive to the needs of the people. For example, we have announced plans for a visiting homemaker program with the Ministry of Community and Social Services where elderly people, who might otherwise be confined to an institution to obtain necessary care, receive the help that allows them to remain in their homes. And our existing home care programs, which provide visiting nurses and physiotherapists with support from homemakers, are serving more people than ever before. In many cases, familiar surroundings act as therapy – speeding up the recovery process.

We have begun 34 new community mental health programs, bringing the total number of these programs to 276, at a cost of $48 million. For the first time the ministry funded the cost of room and board in eight residential addiction programs.

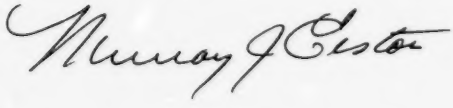
Paramedic services were expanded in Toronto and Hamilton, and we announced they would be established in five other centres throughout the province. The program, which has received a strong endorsement from health care professionals, will help save more lives by enabling victims to receive immediate treatment.

Finally, obstacles to accessible care may arise from something as immutable as geography. Some of our initiatives in 1985/86 were designed to give residents in remote regions better access to health care by improving the air ambulance service and providing grants to cover the cost of travelling to medical facilities which, especially in Northern Ontario, was a serious impediment to obtaining care.

The development of innovative programs like these demands that our health care system be responsive to the needs and wishes of local communities. Representing a rural constituency myself, I know that the health care needs of a rural community are sometimes different from those of an urban community. Our system must be sensitive to both.

Local groups – district health councils, public health agencies, various community groups – play a crucial role in the development of health care because they keep the system sensitive to local conditions and responsive to local needs. I want to involve as many people as possible in the policy-making process. The system belongs to all of us. Everyone has a share in the future of health care.

Yours very truly,



Murray J. Elston
Minister

Message from the Deputy Minister

When I rejoined the Ministry of Health as deputy last year, I quickly renewed my deep appreciation of the size and extent of our Ontario health care system.

By any standard of measurement, we are partners in an extremely large operation. Over 200,000 people are involved in health care in this province. In 1985/86, our total ministry spending was $9.3 billion.

Administratively, our record is an excellent one. While 98 per cent of ministry funds were used directly for health care services such as hospital operations, professional fees, laboratory services, home care, public health and mental health, only two per cent of funding was used to run the ministry. We are clearly an efficient operation and considering the number of programs financed and supported by the ministry we can take great pride in this accomplishment.

Even more important, the quality and level of health care offered to the people of this province is second to none. In Ontario, providers of care maintain a strong dedication and commitment to excellence in health care services.

But we cannot be content with past achievements. Health care is a dynamic and continually evolving activity. We see newly developing technologies, services and methods of care. We see a renewed emphasis on health promotion and disease prevention, and we see a growing need and demand for more community-based services.

Our health care system must be flexible and ready to respond to all these challenges. We must plan for the future with clearly identified goals and clearly identified means for achieving those goals.

This is not only a responsibility for me, as deputy minister, it is a responsibility that must be shared by everyone active in our health care system.

During the coming year, I will be meeting with many of you, listening to your views and hearing your ideas about the future of health care in Ontario. I look forward to working with you.

Sincerely,

Allan Dyer

Allan Dyer, Ph.D., M.D.
Deputy Minister

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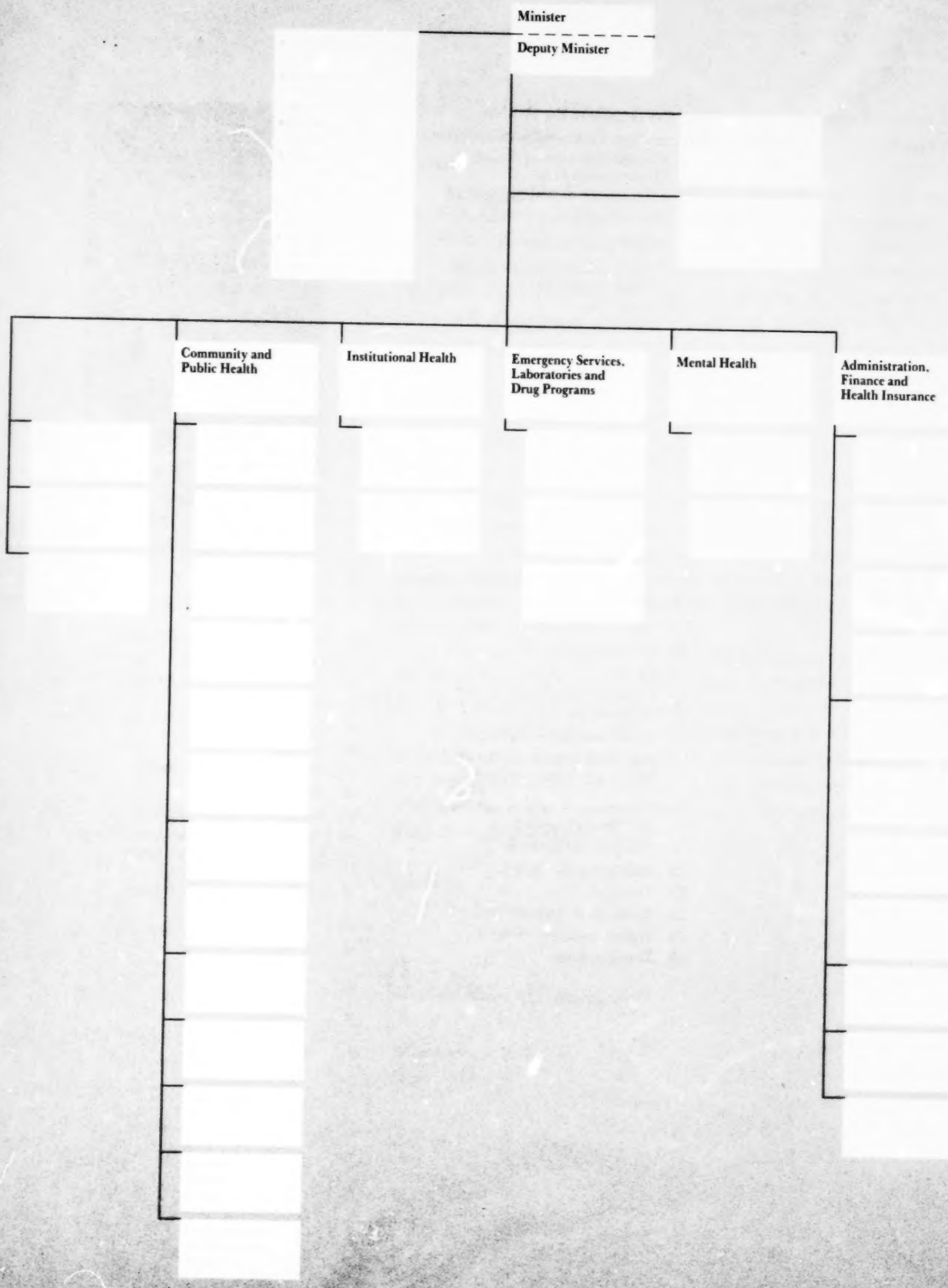
Ontario Ministry of Health
Organization Chart
March 1986



Community and Public Health

Community health organizations play an important part in our health care system. They reflect local concerns and issues, they keep the system in touch with the people it serves and they place a valuable emphasis on health education and health promotion – on wellness, rather than illness. They also provide many different kinds of health care, from the services of chiropodists to the services of public health nurses, that are useful and necessary contributions to the prevention and treatment of disease. The programs developed by the Community and Public Health sector are intended to help in this work, by providing direction, financial support, and expert consultation.

During the 1985/86 fiscal year, representatives from communities across the province met and exchanged views, and this cross-fertilization of ideas has resulted in creative and more innovative programs and better use of community resources. It has also bridged some of the gaps in existing services provided, and improved our understanding of the challenges we face in ensuring that every resident of the province receives the best possible health care.

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"The electron microscope enables me to see in great detail the viruses that are actually responsible for so many of man's diseases, such as the Norwalk virus. This helps physicians make faster and more accurate diagnoses. I find this work very rewarding."

Tina Orchard
Technologist
Laboratory Services Branch
Toronto

Public Health Branch

The function of the Public Health Branch is to promote good health, to monitor the health status of Ontarians, and to control the spread of disease. It does this in part through financial support and expert advice to the 43 local public health units or boards of health in the province which conduct local programs, and in part by developing its own province-wide programs.

Local public health officials are required to report diseases to the ministry and investigate when there are unexpected outbreaks of disease (usually in conjunction with the ministry's Laboratory Services Branch). For example, when outbreaks of gastro-intestinal illness caused by the Norwalk virus briefly closed hospitals and other public institutions in several communities, public health officials were able to identify the virus and recommend appropriate countermeasures.

The Public Health Branch is equally concerned with preventing disease, by measures ranging from better sanitation to vaccinations for school children, and provides funding for local public health agencies in these areas. When outbreaks of disease do occur, the branch works to control the spread of the illness.

An example of a program developed to combat a new disease is the one developed by the ministry in 1985/86 to limit the spread of AIDS, or Acquired Immune Deficiency Syndrome.

AIDS

AIDS is caused by a virus which spreads through sexual contact, blood and other bodily fluids. Like other communicable diseases, diagnosed cases of AIDS must be reported to the local medical officer of health, and through him or her to the ministry's Public Health Branch. Ministry epidemiologists monitor the cases, and analyse population groups who are at risk. About 40 per cent of all cases of AIDS in Canada are in Ontario, and about 70 per cent of the Ontario cases are in Toronto.

In 1985/86, the ministry took steps to limit the spread of AIDS:

*Blood screening tests were established through a $1 million grant to the Ontario Branch of the Red Cross Blood Transfusion Service. Since November 1985, all blood donations have been screened for HIV (Human Immunodeficiency Virus) and chances of the disease being spread through blood transfusions are now remote. The screening test is also available to doctors to help them diagnose AIDS and related diseases and to help identify persons who carry the virus – and who can transmit it to others – but who have no symptoms of AIDS.

*Public education programs were started to inform the public about preventive measures and to encourage knowledgeable and compassionate treatment of sufferers. The ministry provided a grant of $200,000 to establish the Ontario Public Education Panel on AIDS and to prepare a series of five fact sheets in seven languages. Approximately four million copies of these fact sheets have been distributed in Ontario and across Canada. Audio-visual presentations have also been developed and a speaker's referral service has been established with a toll-free number (1-800-387-5586).

*Grants were given to the AIDS Committee of Toronto (ACT) which runs educational and support programs for people with a high risk of being exposed to the AIDS virus. Substantial grants were also awarded for AIDS research projects.

■

"I work with the school immunization program. We look after all the school children from junior kindergarten to 18 years of age. We give innoculations against the common childhood diseases, and skin tests for tuberculosis for the kindergarten children. We innoculate 500 to 600 students a month. I've been doing this work for 10 years and I love it."

Pat Smylie RN
Thunder Bay District Health Unit

The rate of increase in the number of cases of AIDS appears to be levelling off, although no one can predict with certainty the future trends. The Public Health Branch will continue to monitor cases of AIDS, and will take other steps to control the spread of the disease.

Rabies

The Public Health Branch is also trying to control the spread of rabies in animals, which will probably reach its highest point in modern history in 1986. In the first three months of the year, there was more than an 80 per cent increase in the number of cases, compared with the same period in 1985; treatments for people exposed to rabies were up 112 per cent over the same period in 1985.

In December 1985, a new regulation was passed which allows local health boards to order compulsory rabies vaccination for cats, dogs and other animals. So far, five boards of health have begun compulsory vaccination programs.

Food-borne diseases

Inappropriate or careless food handling can spread disease. In 1986, the branch produced an educational campaign aimed specifically at food handlers and supervisory staff in health care institutions. Called "Think Clean", the program stresses the importance of cleanliness and safe food handling practices.

The ministry distributed more than 600 videotapes, teaching manuals, fact sheets, and posters to hospitals, nursing homes and other health care institutions involved in the "Think Clean" program.

Immunization

Last year, the ministry provided $11 million for all immunization programs in the province. By the end of March 1986, 96 per cent of children in kindergarten to grade six were fully immunized against diphtheria, tetanus, polio, measles, mumps and rubella.

Promoting good health

In addition to controlling disease, the branch also supports programs to promote healthy lifestyles. Public health nurses work in the schools, providing preschool health assessment for children, vision and hearing tests, dental health education, family planning counselling and other health education programs. Local boards of health also offer community preventive health services – providing nutrition education or offering prenatal and parenting education classes – and the branch provides funding and expertise for these programs.

The Public Health Branch also routinely reviews statistics on live births, still births, congenital anomalies and cancers in the province.

Community health studies are supervised by the branch and provide important information on the health of Ontario communities.

■

"Basically, we provide a continuity of care once the patients are discharged from the hospital. We help them maintain their lifestyle at home rather than having to be admitted to an alternative facility for care, such as a nursing home or a home for the aged."

Patricia Domino
Physiotherapist
Home Care Program
Toronto

Community Health Branch

The Community Health Branch also works closely with local health care agencies and associations, but its major purpose is to promote and support community-based health projects, especially those that provide alternatives to institutional care for the elderly.

One such project is the Integrated Homemaker Program which was announced in January. It sends a visiting homemaker to disabled or frail elderly people to help them live independently in the community, rather than in a hospital or nursing home. The homemakers are also able to arrange for medical care or professional health services like nursing. The elderly will not need to be referred by a physician in order to get the services of a homemaker, a change from the existing Home Care Program.

The Integrated Homemaker Program is funded by the Ministry of Community and Social Services, but administered by the Home Care Program of the Ministry of Health. The new service will be operated on a trial basis in six communities: Huron, Kitchener-Waterloo, Parry Sound, Cochrane, Thunder Bay, and Leeds, Grenville and Lanark.

Home Care Program

In contrast to the Integrated Homemaker Program, the existing Home Care Program provides professional health services – nursing, for example, or physiotherapy – for individuals who are recovering at home from an acute illness or other health problems. The program not only allows patients to recover at home and frees a hospital bed for those who need more intensive health care, it also offers an alternative to nursing homes for those with chronic health problems.

For the past two years the home care area has also assisted health programs operated by local school boards. Home care staff develop individual care plans for students who are disabled or who need special support to function in educational settings. These programs may include visiting nursing services, physiotherapy and occupational therapy, which are provided during the student's school day.

Across the province in 1985/86, 180,000 patients received these services through the 38 existing home care programs. They provide a relatively inexpensive and convenient alternative to institutional care, and the number of people using these programs is growing steadily.

Health Service Organizations

A third alternative to traditional health care is the Health Service Organizations (HSOs). An HSO is a medical practice that receives funding directly from the Ministry of Health on the basis of a set amount per person per year, based on the age and sex of the patients in the practice, rather than the usual fee-for-service payments through OHIP.

The HSO may also earn "bonus" payments if the rate of hospitalization for its patients is lower than the rate in the community at large. This is an incentive to offer services which not only treat disease, but also prevent illness.

There are now 25 HSOs in Ontario – five new ones began in 1985/86 – and they employ a variety of health care personnel in addition to doctors. Because it is not constrained by the need to bill for specific treatments, the HSO is encouraged to focus on health promotion and illness prevention, and on a team approach to health care and health education.

Community Health Centres

Community Health Centres offer another important alternative to institutional care. The centres are staffed by a cross-section of health professionals, for example, physicians, nurse practitioners and chiropodists. They provide service for specific target populations based on local needs.

All Community Health Centres are non-profit organizations operated by community boards and funded by the ministry. There are now 11 centres operating in the province; two others have been approved and are under development.

Assistive Devices Program

The special equipment and medical devices needed by disabled people can be extremely expensive. In 1982, the ministry established the Assistive Devices Program to pay up to 75 per cent of the cost of medical devices like wheelchairs, artificial limbs, hearing aids or respiratory aids for persons eligible for program benefits.

In 1985/86, the program was extended to include benefits for people up to the age of 22. It helped about 15,000 young people and their families to buy some 32,000 pieces of specialized equipment. Benefits totalled $8.5 million.

■

"This is an Epson communication device, and it allows my son Joe to carry on a conversation. It's a voice synthesizer. He can type a message and the machine will "speak" for him. It's a terrific machine, but it's very expensive. We're leasing it and the Assistive Devices Program is paying part of the cost. It enables Joe to converse, to really enjoy a social occasion and to participate fully in life. I'm very proud of him."

Mrs. Maureen Franze (right)
Thames Valley Children's Rehabilitation Centre, London

■

"I've been a volunteer for 10 years. We do a little bit of exercise and a little bit of singing. Everybody enjoys it; that's why we call it Fun and Fitness. I started volunteering because I really miss old people around me. I grew up in a small village in Germany where old people were a part of the community and as a child, I got a lot from them."

Klara Kemper
Volunteer
Tyndall Nursing Home
Mississauga

Nursing Homes Branch

At the end of March 1986, there were 332 nursing homes in Ontario, with 29,867 beds. The Nursing Homes Branch is responsible for licensing and inspecting those homes, and for ensuring that the people who live in them receive the best possible care.

Nursing home operators are required to provide programs that will enhance the quality of life for the residents, and the branch inspects nursing homes to see that they do. Every home in the province is given a regular detailed inspection at least once a year; in addition, nursing homes are inspected before they are licensed and when their ownership changes hands. The inspectors are experts in nursing, nutrition, environmental health and fire safety. They regularly conduct follow up visits and unscheduled inspections.

Every complaint about the care a resident receives or about the operation of a home is investigated by inspectors. When deficiencies are found, the home must submit a plan showing how they will be corrected, and a timetable showing when they will be corrected.

The annual re-licensing inspection report of any nursing home is available to the public.

In 1972, when the Nursing Homes Act came into force, the need for nursing home beds was so great that the ministry licensed many homes that were already in operation, even though they failed to meet the structural standards set out in the act. In 1985/86, a program was started to bring those homes up to the normal standard through the Compliance Plan Review Board, which examines the structural and environmental conditions of each nursing home, and makes recommendations on ways to bring substandard homes into compliance with the law.

District Health Councils

District Health Councils (DHCs) are autonomous organizations run mainly by volunteers who advise the minister on local health issues and help to plan health care facilities in their own regions and communities. Each council receives financial assistance from the Ministry of Health and has a small professional staff paid by the ministry.

About 450 volunteers are appointed by the government to serve on the councils – about 40 per cent of them are local health care providers, 40 per cent local citizens and 20 per cent representatives of local governments. Furthermore, over a thousand individuals participate on subcommittees and task forces supporting the councils.

The councils make sure that local health care facilities meet the needs of the community. They have been successful in performing that function – so much so that they have been asked to play an even larger part in assessing the role of health care institutions. At the end of March 1986, there were 26 DHCs serving more than 90 per cent of the province's population. Formation of a council in the Parry Sound-Muskoka region is currently being considered.

Underserviced Area Program

Attracting health care professionals to remote parts of the province continues to be a challenge. The Underserviced Area Program was established in 1969 to provide incentives to doctors and other health professionals to practise in remote communities. The program is regarded as one of the most successful of

its type in the world; in the past 16 years, 359 general practitioners, 128 specialists, 94 dentists and 29 physiotherapists have been placed in underserviced areas.

In co-operation with the Ministry of Northern Development and Mines, the Ministry of Health provides bursaries for health care professionals to help pay for the cost of their training. The students agree to practise for one year in an underserviced area for each year of funding they receive. Preference is given to students from the North, and to those who speak French.

In the 1985/86 year, the program placed 43 general practitioners, 41 psychiatrists, 27 other specialists, nine dentists (including one specialist) and seven physiotherapists in communities and regions that would otherwise have lacked these services. For example, two periodontists are now practising in Northern Ontario, and the ministry hopes to attract other dental specialists for all major centres in the North.

The program also provides dental care for children in remote communities through the Northwestern Health Unit Dental Program and six mobile dental coaches that take dentists and their equipment to areas where no other dental care is available. During the year, these programs treated approximately 3,300 preschool and elementary school children. Dental care was also provided for 490 disabled people in the Cochrane-Timiskaming area through the Mobile Dental Clinic for the Disabled stationed at the resource centre in South Porcupine.

■

"Nipissing Village is about 15 miles southwest of North Bay. I've been doing this for 15 years. I was in private practice for 22 years before that. I enjoy this kind of work. I work with children all the time and they're great to work on. That's what I was trained to do, work on children. In some of the areas, there isn't any other dental care available. My wife and I park right at the school and the children come to us. We complete about 75 kids a month."

Dr. Fred Haldenby
Mobile dental coach
Nipissing Village

Mental Health

Treatment and approaches to mental health are gradually moving out of institutions and into programs within the community. While it is our responsibility to ensure that appropriate community programs are available, we are also involved in reviewing and updating programs and treatments offered in the province's 10 psychiatric hospitals. It is the ministry's intention to develop a comprehensive, balanced system of institutional and community-based mental health services that will meet the needs of the people of Ontario.

Ministry staff are regularly reviewing developments in the field to ensure that health care in Ontario reflects the most current understanding of mental illness and mental health. The ministry will also support its programs by educating the public to understand the nature of mental health problems.

Psychiatric Hospitals

In addition to psychiatric units within public hospitals, the Ministry of Health operates 10 psychiatric hospitals in the province. Each hospital operates under the guidance of a community advisory board, appointed by the Minister of Health, which identifies local needs and promotes awareness and understanding of mental health within the communities. In 1985/86, the cost of operating the psychiatric hospitals was $273.9 million.

There were important developments during the year that will lead to significant changes in the way the psychiatric hospitals operate. Several hospitals underwent thorough reviews to ensure that the treatment they provide is appropriate and that their facilities are adequate.

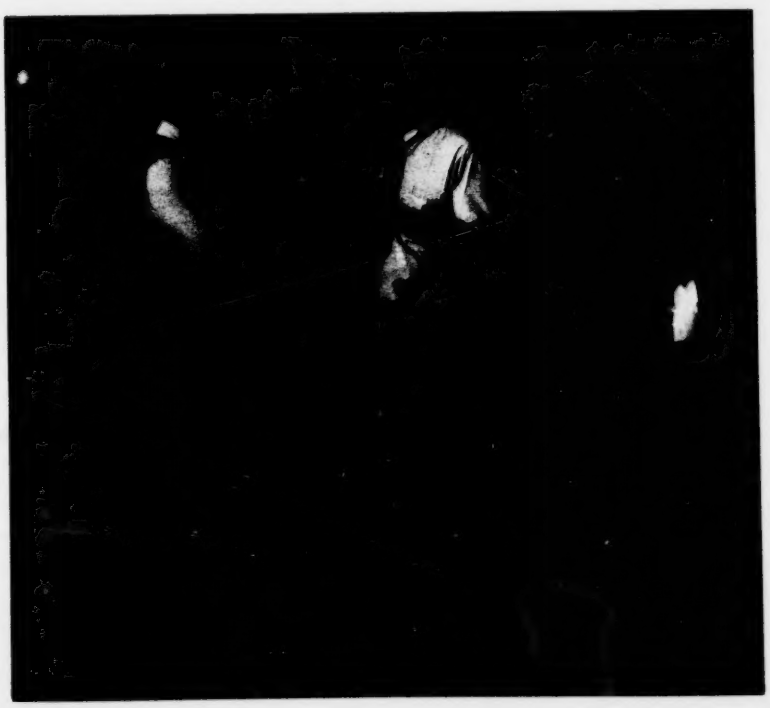
Psychiatric Patient Advocate Program

For the past four years, the Psychiatric Patient Advocate Program has advised psychiatric patients and their families of their legal rights. In 1985/86, an independent committee was established to evaluate the program, and the quality of the services provided to patients and their families.

■

"In terms of leaving, the patients may want us to help them get out. In terms of their medication, our job is not necessarily to help them make a decision, but to remind the staff – or point out to the staff – that the person has the legal right to make this choice or that choice. So it's really more to ensure that the patients' wishes are respected."

Michael Mullan (right)
Psychiatric patient advocate
Queen Street Mental Health Centre
Toronto



Review of services

During 1985/86, reviews of the operations and facilities were conducted at the Oak Ridge Division of the Penetanguishene Mental Health Centre and Whitby Psychiatric Hospital. In addition, a special committee was appointed to assess mental health needs in northeastern Ontario, and to suggest a model system for the delivery of mental health services in that region.

The Oak Ridge Division of the Penetanguishene Mental Health Centre is the maximum security treatment centre for men. An independent committee appointed to review the operation of the division published its final report in December 1985.

A steering committee has been established and meets monthly to supervise the implementation of the report's recommendations. Oak Ridge Division now has separate administration and a team of psychiatrists from the University of Toronto is providing psychiatric services there. As well, expert consultation is being provided to the nursing program.

Eight housekeeping staff at Oak Ridge were hired in response to the Hucker Committee recommendation that indicated many such duties were carried out by patients. Oak Ridge Division is now in the process of recruiting a forensic psychiatrist and 12 registered nurses. Renovations to improve living conditions on the wards are also underway.

At the Whitby Psychiatric Hospital, the Community Advisory Board has recommended the development of a comprehensive community-based approach to mental health care in the area. In addition to the redevelopment of the Whitby Psychiatric Hospital, the committee recommends adding psychiatric beds to the region's general hospitals and enhancing community mental health programs. The Whitby Psychiatric Hospital would serve mainly as a regional referral centre and as a treatment facility for patients with special needs while the general population could receive psychiatric treatment in their own communities.

A submission reflecting this direction is now under consideration by the ministry.

Finally, a steering committee and a consultant were appointed to assess mental health services and requirements in northeastern Ontario. Based on the information gathered through questionnaires and public meetings, the consultant and the committee have recommended a model system for mental health services in the region. The final report, entitled "A Proposed Model for Northeast Ontario Mental Health Services", is completed and has been forwarded to the Ministry of Health for consideration.

Information systems

Computerized information systems are to be installed in all 10 provincial psychiatric hospitals by April 1988.

A mental health data base will contain information on community mental health programs and the services provided by each of the provincial psychiatric hospitals.

University affiliation

Provincial psychiatric hospitals are becoming affiliated with the Health Sciences Centres at universities across the province. The purpose of the affiliation is to encourage more teaching and research within psychiatric hospitals. By the end of March 1986, eight of the 10 provincial psychiatric hospitals had reached agreements with universities. The final two affiliation agreements will be concluded in 1986/87.

Charter of Rights

Provincial mental health legislation in Ontario, as well as in other provinces, must be consistent with certain basic rights set out in the Canadian Charter of Rights and Freedoms. In 1984, the Uniform Law Conference of Canada was asked to draft a Uniform Mental Health Act consistent with the charter which could serve as a model for provinces preparing to amend their legislation.

Representatives of seven provinces and territories began meeting in 1985, and prepared a draft Uniform Mental Health Act which was circulated to national interest groups in 1986. A second round of consultations is taking place before a final draft is submitted to the Uniform Law Conference in 1987.

In the meantime, several amendments to the Ontario Mental Health Act have been put forward before the Ontario legislature. The proposed amendments would generally strengthen the rights of patients in psychiatric facilities, for example, by giving them the right to challenge before a review board certain judgements that they are mentally incompetent (which may result in others making important decisions on their behalf). As well, patients in psychiatric facilities would be given the right to see their own clinical records with only limited exceptions.

Community-based Mental Health

Throughout 1985/86, the ministry continued its trend toward deinstitutionalization and the development of alternative, community-based programs. Priority is given to programs that provide community support for former psychiatric patients, reduce duplication of services, provide outpatient services for the elderly and offer self-help and vocational rehabilitation.

Programs funded by the ministry are evaluated regularly to ensure that they are well-managed, and that they meet local needs.

During 1985/86, the ministry provided $4.7 million in funding for 34 new community mental health programs. The total annual budget for community mental health programs is more than $48 million, and that provides funding for 276 community programs. In addition, the ministry funded 17 new alcohol addiction programs.

Addiction services policy

In December 1985, the ministry announced a new addiction services policy designed to ensure that every resident of the province has equal access to a variety of community-based addiction services and programs. Under the new policy, for the first time, the ministry will fund the full cost of community residential addiction programs, including charges for room and board. The ministry believes that the new policy will encourage the development of less costly – but equally effective – community treatment programs to supplement existing institutional services.

Homes for Special Care Program

The Homes for Special Care Program has provided long-term care for former psychiatric patients since 1964. Individuals who require nursing care live in nursing homes throughout the province; those who require only some supervision live in program boarding homes. A consultant was hired to recommend changes to the program that would enhance the quality of life for people in the homes. The consultant's recommendations have been received by the ministry, and discussions about their implementation are under way.

Improving community housing for former psychiatric patients

The ministry is also expanding programs to improve housing for former psychiatric patients. During 1985/86 the ministry made $1.5 million available to municipalities that operate boarding homes that provide housing for former psychiatric patients.

Under the boarding home contract program, municipalities can apply for funding to make necessary repairs to the buildings and to develop new social programs in the homes. As part of the contract agreement, the ministry also provides the services of community mental health supportive care staff. The additional cost of the care is $900,000. In this way, the ministry is not only improving the living environment, but providing the support that former psychiatric patients may need in becoming integrated back into the community and the workforce.

■

"We have a 35-day program that offers intensive psycho-social treatment for alcohol dependency, the first service of this kind for francophones in Ontario. The new grants for residential treatment allow us to serve many more people. It isn't really an expansion, because no programs like this existed before, that allow francophones to be treated in their own language. We're treating three times as many people as we used to, with the same facilities."

Georges Morin
Executive director
Maison Fraternité
Ottawa

Emergency Health Services, Laboratories and Drug Programs

Medical science is progressing very rapidly in the fields of emergency health, laboratory techniques and drug therapy. Over the next 20 years we will see remarkable changes in emergency techniques, in laboratory equipment and procedures, and in the range and types of drugs available to treat illness.

One of the areas where great advances are expected is in the rapid diagnosis of illness, particularly in viral diseases, and in immunology. This is due in part to the increasing use of electron microscopes, which permit the direct examination of viruses, and which speed up the diagnosis of viral diseases. Great strides are also being made in immunology: within the next decade, we may see a whole new family of vaccines with increasing emphasis on the prevention, rather than the treatment, of disease.

Emergency Health Services

The capacity for fast response – to the tornado in Barrie, to a man suffering cardiac arrest in Hamilton, to a woman in premature labor in Kirkland Lake – is the standard by which Ontario's emergency system is measured. But attaining the high standard the system enjoys now depends on the smooth teamwork of the people who make this system effective. Each of them plays a different part, and each must play it well.

Few residents of central Ontario will forget the night the tornado hit. It was May 1985. The storm cut a wide swath through the central part of the province. The places where it touched the earth – Shelburne, Tottenham, Orangeville and Barrie – were marked by millions of dollars in property damage. Homes and buildings were reduced to rubble, and hundreds of people were injured. Twelve people died.

Ontario's emergency health services system went into action within minutes. In the next eight hours, hundreds of injured people received emergency medical attention from ambulance personnel, hospital staff and Red Cross volunteers. It was a dramatic demonstration of the ability of the province's emergency health system, in particular its central ambulance communications, to respond quickly to disaster.

Emergency attendants

Ambulance attendants are the heart of the emergency care system. In 1985/86, the Ministry of Health examined and certified 281 new ambulance attendants; in future all attendants will be re-certified on a regular basis, to give them the opportunity to update and improve their skills.

However, the attendants can only be as good as their equipment. Ontario's land ambulance system includes 454 single-stretcher vehicles, 104 dual-stretcher vehicles, 25 four-wheel drive vehicles, five multi-patient vehicles, five critical care transport units and 14 emergency response units. In 1985/86, that fleet moved more than 760,000 patients.

In addition, the ministry operates air ambulances that transport patients in helicopters or fixed-wing aircraft. The air ambulances moved 12,401 patients during the year, and the service is now available in almost every part of the province. Beginning in November 1985, the five dedicated air ambulances began providing 24-hour service, which greatly improves access to emergency transport for people in remote parts of Ontario.

During 1985/86, important improvements were made in air ambulance facilities. New hangars in Sudbury, Thunder Bay and Timmins now make it possible for indoor patient transfers from land to air ambulances. Similar indoor transfer facilities are also available at Pearson International and Toronto Island Airports. In addition, 10 new 24-hour heliports have been constructed to bring the total number in the province to 63. The heliports are located close to health care facilities and reduce the need to transfer patients from helicopters to land ambulances.

Paramedics

Paramedics are ambulance attendants who are trained to provide certain, designated medical acts – to administer drugs, for example – at the emergency site under the supervision of a doctor who relays instructions by radio. In 1985, successful pilot projects were completed in Toronto and Hamilton on the use of paramedics; up to five more communities will introduce paramedic teams in 1986/87 as a result of these pilot programs.

Paramedics at the scene of an emergency must work closely with the physician at the hospital. The doctor must be able to respond to the many challenges inherent in emergency situations, and trained to make medical decisions on the basis of information provided over the radio by the paramedic. In 1985/86, the ministry provided funding for 29 post-graduate positions in emergency medicine.

■

"The Ministry of Health probably has one of the best critical care services running right now in North America. With its various pilot programs and use of paramedics, it has been in the forefront of pre-hospital care for years. It's great to be part of it."

John Wultchyn
Critical Care Attendant (centre)
Aurora

Volunteer ambulance services

Volunteer services are a vital part of Ontario's ambulance system. They are used extensively – and successfully – in small communities or remote parts of the province, areas where the number of calls may range from one per week to one per day. There are 32 volunteer ambulance services in Ontario with a total of about 900 volunteers; another 50 regular ambulance services use volunteers to supplement their paid staff. About one third of the province's entire ambulance staff are volunteers, and their contribution is invaluable.

Communications network

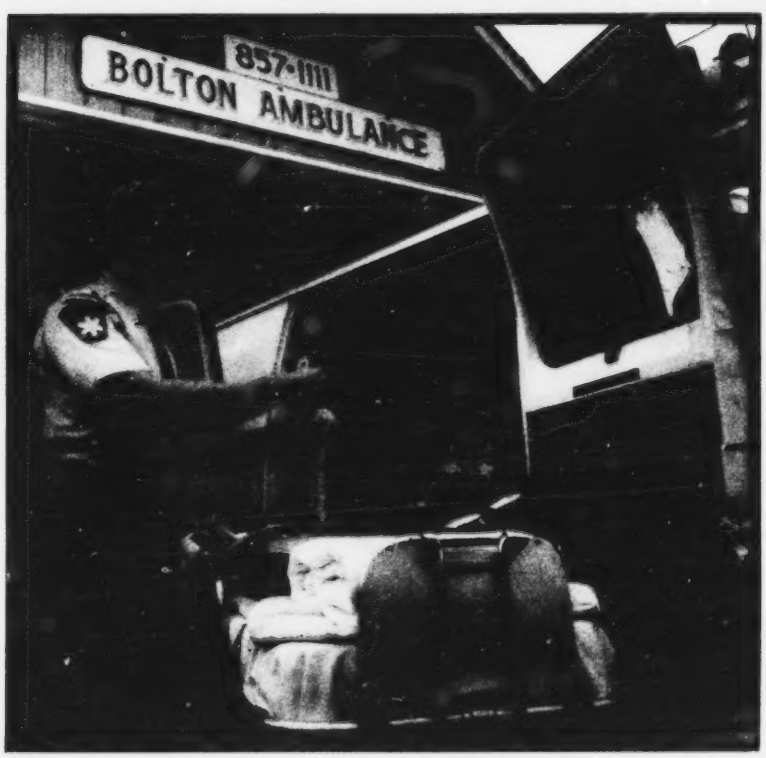
A highly-effective communications network is used to co-ordinate patient transfers in the emergency response system. All air ambulance flights are arranged by a single computer-assisted central communications centre which covers the entire province; most land ambulance calls are also arranged by centralized communications systems organized on a regional, rather than a province-wide, basis.

These regional communications centres can co-ordinate their response in a large-scale emergency. For example, during the 1985 tornado disaster, the regional centres and the air ambulance communications centre co-ordinated 70 ambulances and emergency response units to make the most effective use of the available equipment and manpower.

During 1985/86, regional Central Ambulance Communication Centres were established in Mississauga, London and Thunder Bay, for a total of 18 such centres in the province. Expansion of this regional network is being planned.

"There's an inner feeling of peace and satisfaction in providing care. I have a great sense of pride in belonging to both my community and to the health care system."

Doug Johnston
Volunteer ambulance attendant
Bolton



In addition, the central air dispatch system provides a special service for health professionals: it keeps track of the number and location of hospital beds available across the province for premature babies and new-born infants. A doctor who wants to transfer an infant to a hospital with specialized facilities can make one phone call and identify the nearest hospital that can accept the child.

The same tracking and communication system was used to set up a Central Bed Registry in Hamilton. All of the available hospital beds in the area are registered, and physicians – or ambulance communications centres – can easily learn where to obtain the facilities they need. The program has been so successful that similar registries are being established in Toronto, Ottawa, Windsor, London, Sudbury and Thunder Bay.

Sophisticated communications networks are also used to exchange information within the health care system. For example, in northwestern Ontario, where the distance between centres is great, a facsimile network is used to link 18 health care institutions so that documents – the results of a patient's lab tests for example – can be exchanged over the telephone lines.

In the same way, a different communications network is used by Telemedicine for Ontario, a project which uses teleconferencing to provide educational programs for health care workers across the province, but especially those in remote or isolated communities. Participation in the program increased by 60 per cent in 1985/86; the number and type of programs provided is constantly growing.

Looking ahead

To better evaluate and improve emergency services, the ministry has established the Provincial Emergency Health Services Advisory Committee to develop provincial standards which communities can apply to their local situations.

For example, a working group established by the committee has developed guidelines to categorize trauma facilities according to the services they provide. These guidelines will be used by local communities to assess their capacity to deal with injuries and to identify centres of excellence for trauma care.

Laboratory Services Branch

The Laboratory Services Branch provides testing facilities for public health authorities in the province. When an outbreak of disease occurs, this branch is responsible for determining the causes. There were several such public health crises in 1985/86: an attack of the Norwalk virus briefly closed a number of hospitals in the province; the E.coli bacterium caused 19 deaths in a nursing home in London; and the number of cases of AIDS in the province increased from 84 to 211. The Laboratory Services Branch was involved in all of these cases.

In all, the branch performed about 3.3 million lab procedures in 1985/86, an increase of almost eight per cent over the previous year.

The branch is constantly looking for new tests and lab procedures which will make it easier to identify the organisms that cause disease. Five new procedures or new applications of existing procedures were developed by the branch in 1985/86:

- a better test to detect the organism that causes Legionnaires' disease is now being used to routinely screen urine samples. The test is the first of its kind in the world, and it allows much faster and more efficient diagnosis;
- electron microscopy techniques were used to identify the virus that caused 25 outbreaks of gastroenteritis in several hospitals and public institutions during the year;
- a rapid screening technique was developed to quickly identify the E.coli bacterium responsible for several outbreaks of gastroenteritis;
- blood tests have been developed which identify people who have been exposed to the AIDS virus, even though they may have no symptoms of the disease. In November 1985, the branch began testing blood samples submitted by doctors for diagnostic purposes;
- routine testing of stool samples for the parasite cryptosporidum was begun in 1985/86. The parasite has long been known to attack animals and has now been shown to cause abdominal pains, diarrhea and dehydration in humans. It could be serious in people with impaired immune systems, such as AIDS victims or young children.

The fast diagnosis of diseases caused by viruses is increasingly important, so routine virology testing services are gradually being extended to more regional public health laboratories. Virus isolation is now done routinely in Thunder Bay, Timmins, Windsor and Kingston and, to a limited extent, in Ottawa.

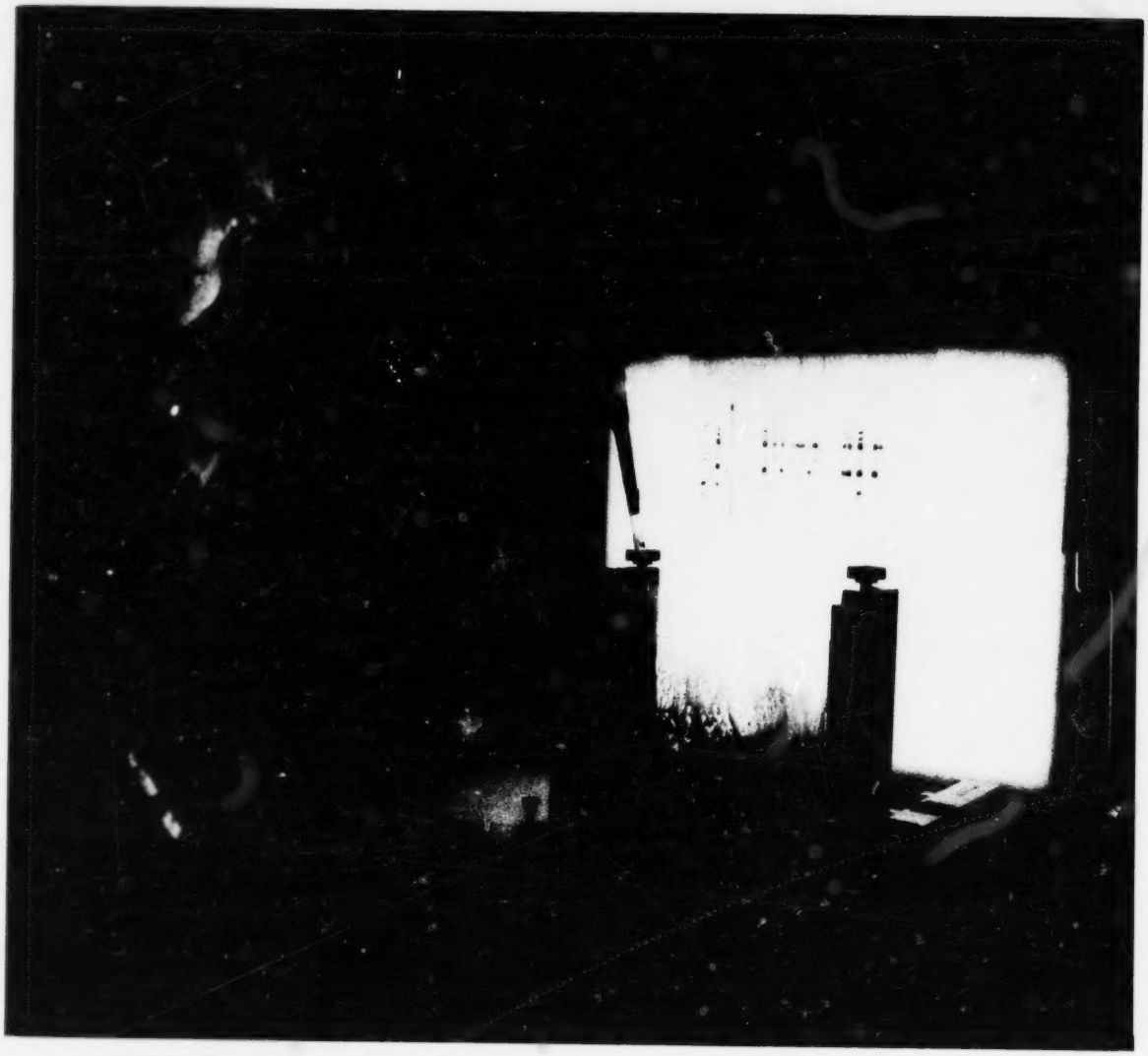
New tests have also been introduced to supplement existing procedures for identifying chlamydia infections, a service used extensively by family planning clinics and clinics treating sexually transmitted diseases.

Drug Programs

In 1984, a commission was appointed to study drug pricing and the availability of drugs in Ontario. The commission's report resulted in two new pieces of legislation, which were introduced in November 1985: The Ontario Drug Benefit Act and the Prescription Drug Cost Regulation Act. Both acts will benefit consumers by ensuring that drug prices are realistic and competitive, and will improve the management of the Ontario Drug Benefit Plan.

When bills 54 and 55, as they were known, were introduced, comment on both bills was sought from interested groups: consumers, pharmacists' associations, doctors' organizations, hospital associations and senior citizens' groups. Public hearings were also held in early 1986, amendments were made, and the legislation was to become law by the end of the year.

When they are enacted, the bills will eliminate unnecessarily high drug prices, and improve the range of drugs available. The bills contain provisions that allow less-expensive generic drugs to be substituted in prescriptions, and that assure the quality of drugs sold in the province. The one-month limit on prescriptions under the Ontario Drug Benefit Plan will be removed, which will enable people getting these benefits to receive longer-term prescriptions.



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"I am a senior technologist in the AIDS laboratory. I am loading a gel for the Western Blot test which is used to confirm the presence of (HIV) Human Immuno-deficiency Virus antibodies in human blood samples. I recognize the importance of my role as part of the team which is actively involved in applying "state of the art" technology towards the laboratory diagnosis of the HIV infection."

Brian Gregory
Senior technologist
Laboratory Services Branch
Toronto

Ontario Drug Benefit Plan

The Ontario Drug Benefit Plan, administered by the Ministry of Health and the Ministry of Community and Social Services, pays the cost of prescription drugs for the elderly, the needy and residents of extended care facilities or homes for special care. These people frequently need high levels of medication, but they are often poor, and the high cost of drugs can be a deterrent to receiving adequate treatment. The Drug Benefit Plan is designed to eliminate that deterrent.

In 1985/86, the plan processed 30 million claims, and paid out $413 million, an increase of 18.7 per cent over the previous year. The average cost of each claim was $13.15, which included a dispensing fee of $4.97 for prescription drugs.

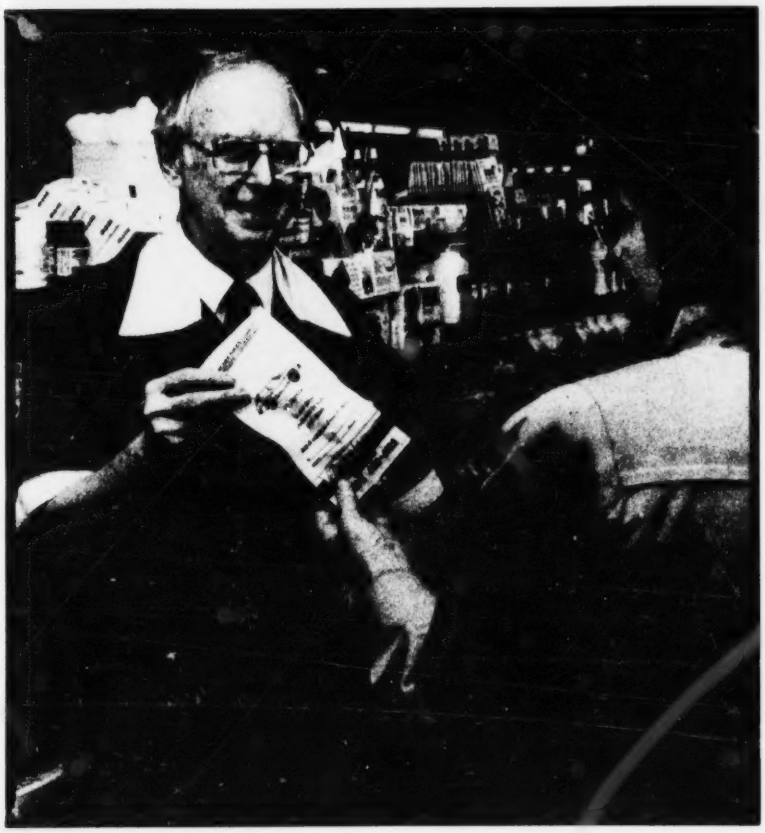
Drug Quality and Therapeutics Committee

The Ministry of Health is frequently approached by drug manufacturers who want to have their new products listed as benefits, and by generic drug makers who want to have their new products listed as "interchangeable" with other brands of the same drug. The ministry reviews each of these requests and does quality tests on the new drugs. Each submission is also reviewed by an independent advisory body, the Drug Quality and Therapeutics Committee, which is made up of experts in medicine, pharmacy and clinical pharmacology. By this careful review, the ministry ensures that people in Ontario have access to high-quality drugs at reasonable prices.

■

"We dispense prescriptions under the Ontario Drug Benefit Plan. We have a lot of older people – shut-ins – nearby, and many have their prescriptions filled here because we deliver. Some can't get out at all. People are living longer now, there are more older people, and it would be a real hardship for quite a few over 65 if they didn't have the plan."

Don Mason
Pharmacist
St. Catharines



Institutional Health

The Institutional Health sector of the ministry works with Ontario's 220 hospitals to provide high-quality health care as efficiently and effectively as possible. As with other sections of the ministry, that goal is achieved by providing funding and expertise to help local, community-based organizations to establish institutional health care programs.

With the money available for health care being limited, the challenge has been to find ways to use these finite resources wisely, both to maintain the existing standards of care and to develop the new services that are needed.

As a result, hospital day programs and outpatient programs have been added which shorten the length of the patient's stay in hospital without reducing the quality of care. Hospitals have co-operated to avoid duplicating the services offered, and new, highly specialized services are offered on a regional basis to be shared within the region.

The Institutional Health sector of the ministry works to ensure that hospital programs are well-managed, and that the available operating funds are distributed equitably across the province. It also manages the planning and funding of hospital construction and renovation projects. Focus will increase on expanded plans for capital construction programs as existing hospitals are modernized and new facilities are built in the rest of this decade and into the early 1990's.

Hospital Funding

During 1985/86, the Ministry of Health provided $4.3 billion solely for operating costs for Ontario's hospitals – a figure that does not include new building programs, building or maintenance costs, new construction or fees paid to doctors.

These operating costs were 8.5 per cent higher than in the previous year, for four reasons:

- the basic allocation for operating funds increased 3.9 per cent;
- there was more demand for hospital services;
- high technology life-support programs increased costs;
- existing hospital services were expanded and new services were offered.

During the fiscal year, the ministry also provided $269.5 million in capital grants to cover construction costs in hospitals and related facilities. That is a substantial increase – 35 per cent – over the previous year, but more than half of the increase ($144 million) represents special payments made to liquidate loans incurred for hospital construction in previous years. The loans had been arranged to finance large construction projects in teaching hospitals. Paying them off will substantially reduce interest costs.

Planning approvals given for capital construction are now long-term rather than year-by-year. This way, hospitals will know years in advance how much funding they will get, allowing them to plan their building programs further ahead.

The current capital funding program will add 4,400 new hospital beds in the course of the next decade. It is the biggest allocation of hospital construction grants in the history of the province and it will help provide the bed needs of the hospital system for the balance of this century.

Construction and renovation projects

During the year, an unusually large number of hospital construction projects were either planned, started or completed. Among them:

- construction began on a $2 million addition to St. Francis Memorial Hospital in Barry's Bay. The addition will house a 17-bed chronic care unit, an ultrasound testing facility, pre-natal and well-baby clinics and a clinic for alcoholics;
- the first phase of the redevelopment of Victoria Hospital in London was completed. The 210-year-old hospital is gradually being moved to a more spacious site, and has been designated a regional health centre;
- St. Michael's Hospital in Toronto has completed the first phase of a major modernization program;
- construction has started on the first phase of a new general hospital in Espanola;
- contracts were awarded for construction of a new hospital in Kapuskasing which will contain 60 acute care and 20 chronic care beds, expanded emergency facilities – including a helicopter landing area – physiotherapy and occupational therapy clinics and a mental health clinic.

■

"We're re-building the Hamilton General Hospital, pretty well the whole hospital. This building varies in date, from about 1893, I think it is, with the last structure going up in 1952 or 1953. The reconstruction will cost $76 million; $62 million, I believe it is, is coming from the ministry."

Dr. E.G. Woodward (right)
Administrator
Hamilton General Hospital

- a $26.5 million grant was approved for construction of a new core facility for St. Joseph's Hospital in Toronto;
- Belleville General Hospital completed construction of its expanded emergency and outpatient facility at the North Hastings District Hospital in Bancroft;
- the new chronic care wing of the Charlotte Eleanor Englehart Hospital in Petrolia was completed;
- the new Credit Valley Hospital in Mississauga was officially opened;
- the Gage Transitional Living Centre at West Park Hospital in Toronto was completed. The only facility of its kind in Ontario, the centre helps physically handicapped but mentally alert adults learn skills that will enable them to leave the hospital and return to life in the community.

Special Health Needs

In addition to large-scale hospital construction and renovation projects, the ministry also finances smaller programs that cater to the special needs of people in remote communities and individuals for whom advanced medical treatment is necessary. Some examples:

Care for the elderly

In the past, elderly people living in Northern Ontario had to move away from their own communities, friends and relations in order to get nursing care. Now extended care units in northern hospitals provide nursing care within the community. New extended care facilities are available in Blind River and Wawa, and others are planned for Matheson, Chapleau and Hornepayne.

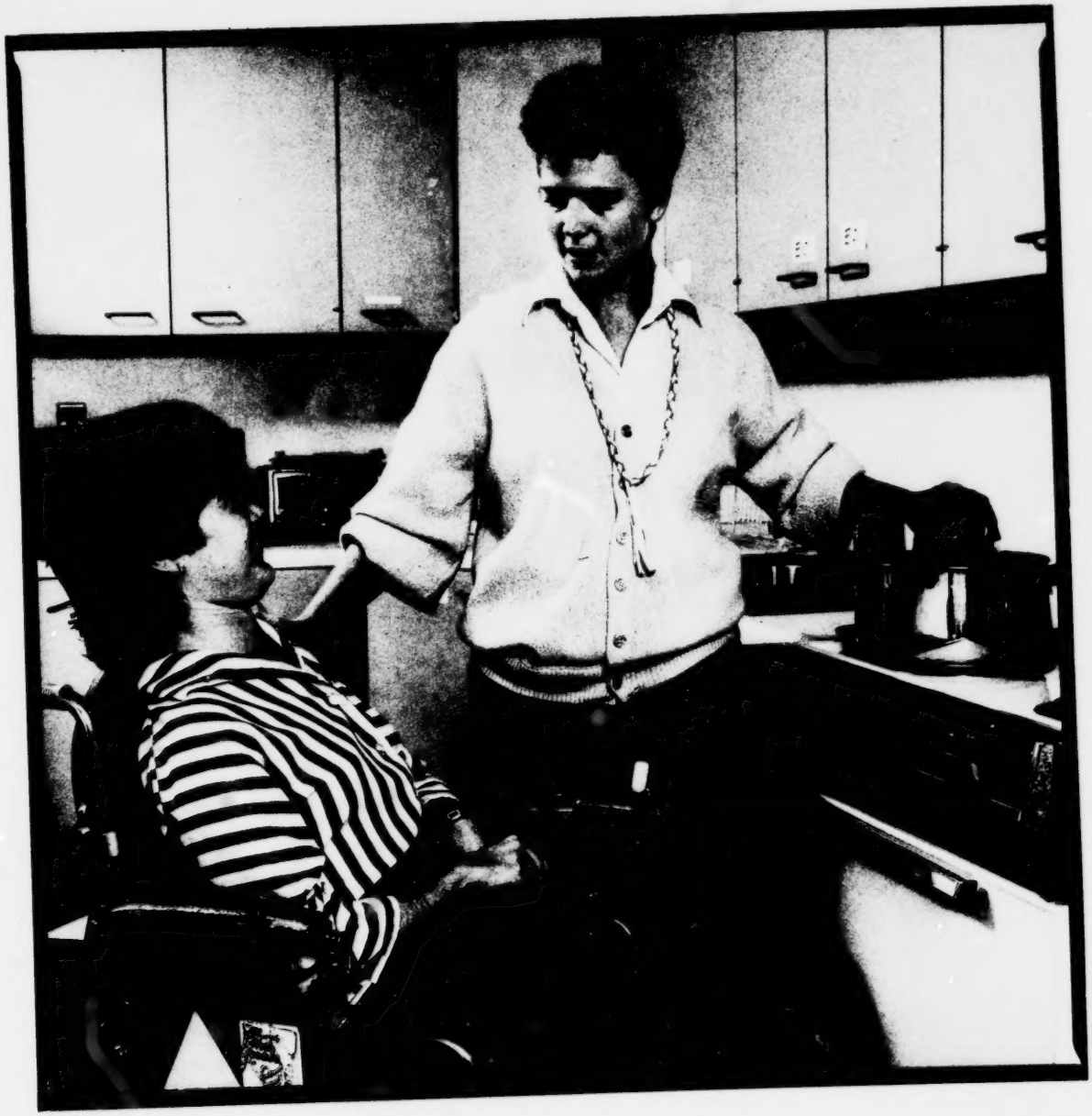
Organ procurement

Some seriously ill patients can be helped immeasurably by organ transplants, but it is well known that donated organs are in short supply. A task force on kidney donations was appointed to investigate this problem, and made its report to the ministry in September 1985. An Action Group on Organ Procurement has been appointed to follow up on the recommendations made in that report. Projects include the publication of guidelines for organ donation to be used by hospitals, as well as brochures for the public and for health professionals. An audio-visual series is being developed to educate health professionals on specific aspects of the organ donation process.

■

"This is one of 300 kidney transplants that were performed in Ontario in the past year but, unfortunately, there are hundreds of people still waiting to have their health restored. This is tremendously exciting work and, hopefully, with more organ donations, we will be able to help those who are waiting."

Dr. Michael Robinette (centre)
Surgeon
Toronto General Hospital



"The Gage is a transitional living centre for people who are moving from an institution or from home, where they've been highly protected. We're trying to help them to be more independent, so they can live alone or with attendant care. We help them to be responsible for their own lives. We might teach them to cook their meals or to do their banking or to write a letter. I find the work challenging."

Terry Waterland (right)
Personal care attendant
Gage Transitional Living Centre
Toronto

The Hospital for Sick Children

In 1985/86, The Hospital for Sick Children received funding for four bone marrow transplant beds. This procedure has a reasonable rate of success and has saved the lives of many children with leukemia and bone cancer who would not otherwise have survived.

The hospital also received extra funding to treat childhood poisoning. The Ontario Regional Poison Information Centre provides telephone information to families, and guidance for physicians who are treating poison cases.

Chiropody

The development of a province-wide chiropody service continues to make good progress. Some 50 chiropodists have now been established in clinics in over 30 hospitals, health units, and community health centres in various parts of the province. In these settings, the chiropodists are salaried employees of the institution.

Patient acceptance of this new service has been excellent, and the chiropodist is proving a valuable addition to health care teams. The main thrust of the service is on outpatient treatment and the maintenance of mobility, particularly in the senior citizen group.

The chiropody teaching clinic at Toronto General Hospital continues to play a leadership role in the program, and delivers a substantial volume of high quality service. The close co-operation and co-ordination of George Brown College, the Toronto Institute of Medical Technology and Toronto General Hospital in the teaching program is resulting in graduate chiropodists who can be relied upon to perform effectively anywhere in the province. Chiropody is proving a popular career choice and there is no shortage of qualified applicants for the program.

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"Everything about The Hospital for Sick Children in Toronto is excellent. They bend over backwards for the children and for the mothers. For instance, the playroom people look after Barbara while I go down and have breakfast, so I can have some time to myself. She's been here for six weeks now, so it's great that they let me stay with her."

Carole MacArthur and daughter Barbara
Hawkestone

It has been recognized from the beginning that nurses have an important responsibility in the delivery of foot care. The Ontario College of Nurses has identified the appropriate level of care that nurses can provide, and action is being taken to introduce appropriate instruction into the community college nursing programs. In addition, regional workshops for nursing personnel, particularly those working in long term care settings, are being carried out.

In spite of this satisfactory progress, chiropodists will continue to be in short supply for some years to come, and effective use of the available manpower is important. To this end, a district service is now under trial.

In vitro fertilization is the process of fertilizing a human egg outside the body and then re-implanting it in the mother's uterus. It is a relatively new technique and one that in many cases offers the last chance for infertile couples to become parents.

In 1985/86, the ministry provided funding for in vitro programs at four locations in the province: Toronto East General Hospital, Toronto General Hospital, Chedoke-McMaster Hospitals in Hamilton and University Hospital in London.

Cleft lip and cleft palate are disfiguring congenital conditions that are normally treated from childhood to adulthood. Medical and surgical costs for treating these conditions have normally been covered by OHIP, but the dental services that are necessary to complete the treatment have not. The cost to families of corrective dental care has been a barrier to treatment for some children.

Starting on January 1, 1986, the Ministry of Health announced a new Cleft Lip and Palate Program that will pay 75 per cent of the cost of necessary specialized dental care. It is estimated that the new program will cost $2.3 million per year and will assist 3,800 families with children who suffer from these conditions – children who might not otherwise have received the treatment they need.

During 1985/86, the X-Ray Inspection Service of the ministry expanded its Quality Assurance Program, a series of relatively inexpensive procedures that allow users of x-ray equipment to identify equipment deficiencies, poor hazard control and incidents of high doses of radiation. The X-Ray Inspection Service checked more than 3,500 pieces of x-ray equipment during the year.

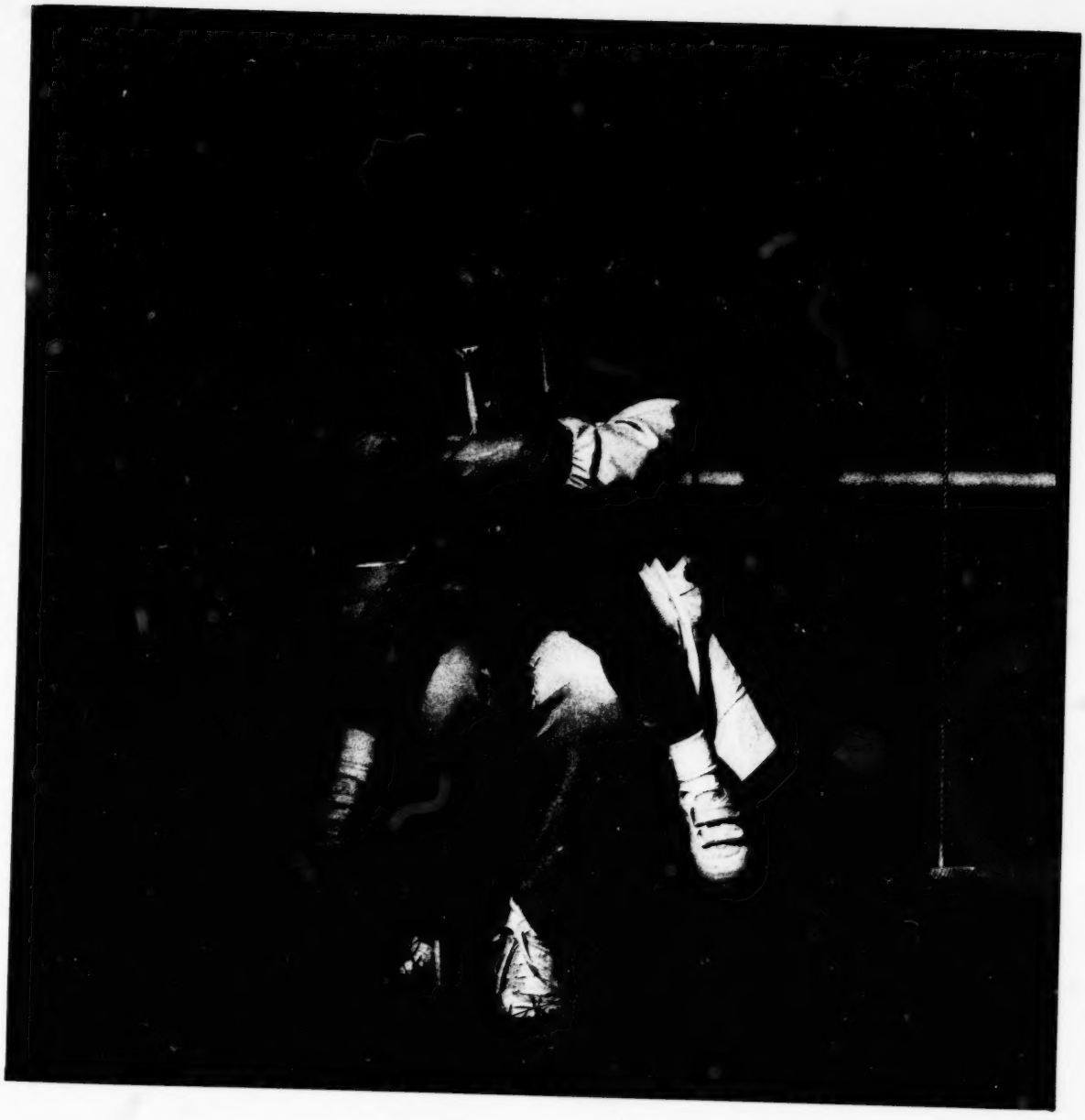
X-ray practitioners who did not meet safety standards were reported to their own licensing bodies, and the service had 100 per cent compliance with its orders without using legal procedures.

Employment Equity

The Ministry of Health is participating in the employment equity Incentive Fund Program with the Ontario Women's Directorate and the Ontario Hospital Association to improve the economic status and career opportunities for women in public hospitals in the province.

The Ontario government, through the Women's Directorate, allocated a total of $1.3 million to finance employment equity demonstration projects and to help hospitals develop and implement employment equity programs.

By the end of March, 72 of the 132 hospitals with more than 100 beds – 55 per cent – had received Incentive Fund grants to undertake employment equity initiatives.



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"The assistance program for special dental treatment will ease an enormous financial burden for us and for many others. The recognition of cleft lip and palate as a complex and total health concern is equally important. We truly appreciate the insight the ministry has shown and their speed in implementing a long overdue program."

Sharlene Pettit and daughter, Brooke
Ingersoll

Administration, Finance and Health Insurance

The Administration, Finance and Health Insurance sector provides administrative services for the ministry and operates the Ontario Health Insurance Program. OHIP constitutes by far the largest part of this workload; in 1985/86, the program handled almost 81 million claims from about 16,000 physicians and other practitioners, and paid out more than $2.7 billion in benefits.

The number of claims continues to increase each year, but the computerized systems used by the ministry make it possible to develop more efficient methods of dealing with the increasing workload.

Health Insurance Division

The Health Insurance Division processes almost 81 million claims each year, and is constantly seeking ways to further improve service.

In 1986, OHIP introduced a new claim card for physicians which allows doctors to code their claims in a form that is compatible with OHIP's computer equipment. The new claim card will enhance confidentiality of patient records, increase accuracy and speed claim payment. The division also produced a manual and an introductory kit which explains how the claim card is to be used. Some 2,000 physicians requested the manual and the kit.

OHIP also encourages doctors to use a computerized billing system known as Machine Readable Input (MRI). In 1986, computer drop-in centres were organized in each district office to demonstrate these systems to physicians. The drop-in centres enable doctors who are considering converting to MRI to review computerized billing procedures, assess the advantages and try out the equipment.

Northern Health Travel Grant

The Health Insurance Division is also responsible for administering the Northern Health Travel Grant Program, which started on December 1, 1985. People living in Northern Ontario often have to travel great distances to receive hospital and specialized medical care.

Under the new program, residents of Northern Ontario who have to travel more than 300 kilometres (one way) for specialized medical treatment may apply for grants to reimburse them for travel costs. The patient is referred by his or her physician to the closest appropriate hospital or medical specialist. The amount of the grant is based on the distance travelled. From December 25 to March 31, there were 6,286 applications for travel grants, and the program paid grants to northerners totalling just over $1 million.

Finance and Administration Division

The Finance and Administration Division provides the services, supplies and procedures – ranging from the purchase of rabies vaccine to fuel for air ambulances – that the ministry needs to perform its functions.

In 1985/86, the division helped establish several new stations and dispatch centres for land and air ambulances. It also helped OHIP improve the facilities in its district offices. In addition, the division completed a number of projects to enhance safety and energy conservation in many of the province's psychiatric hospitals.

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"We were living in Matheson, 30 miles south of Timmins, when I got the grant to travel down to Kingston. I had surgery and had to go back for a check-up. We travelled by car and the ministry paid the mileage. Before those grants came in it was pretty expensive travelling down to the hospital. The grant covered pretty well all of the cost."

Judy Tritton (centre)
First recipient
Northern Health Travel Grant

The division buys supplies in large quantities in order to obtain volume discounts. In 1985/86, for example, the ministry saved $350,000 by buying aviation fuel in bulk, and $200,000 by bulk buying of clothing for employees and patients in various health care institutions.

The division is currently planning to computerize many of its operations, which will improve administrative procedures and reduce costs.

In 1985/86, the Affirmative Action Program, as one of its objectives, focused on areas of the ministry where relatively few women are employed: senior executive positions, technical jobs, positions in general operations and maintenance, and positions at Oak Ridge, the maximum security division of the Penetanguishene Mental Health Centre.

During the year, the number of women in senior executive positions increased from four to six out of 31. Twenty-two women were hired or promoted into positions that lead to senior management jobs. Seven women were appointed as systems officers and 13 obtained positions in operations and maintenance. Since 1983, 17 women have been hired as attendants at Oak Ridge; as well, 531 women received accelerated job experience which prepares them for greater responsibilities.

The affirmative action staff also arranged courses and seminars for 658 women in the ministry to teach executive and administrative techniques and presentation skills.

■

"I was looking for a position which would offer continuous learning and self-development and I found it with the air ambulance service. Affirmative action means that more women like me can get into non-traditional jobs."

Terri Burton
Air ambulance attendant
Buttonville

Special Programs and Projects

Policy Analysis and Research Branch

The Policy Analysis and Research Branch is responsible for analysing trends in the health care delivery system, and for suggesting policies to improve the system. During 1985/86, the branch was concerned with five main subjects: new legislation regulating health professions, the implementation of midwifery, manpower requirements for the health care system, the use of health care services and research projects.

Eighteen health care professions have governing bodies which are empowered by law to set the standards of practice and the requirements for admission to the profession, in order to protect the public. The laws which govern health professions have been under review and in 1985/86, the Minister announced which professions will be regulated.

Seven professions – audiologists, dieticians, medical laboratory technologists, midwives, occupational therapists, respiratory technologists, and speech-language pathologists – have been newly added to the list, bringing the total to 25 from 18.

The review's second task is to define the scope of practice of each of the professions and to specify the powers each regulatory body requires in order to protect the public.

In January 1986, the Minister announced that midwifery will become a regulated profession and a recognized part of Ontario's health care system. He also appointed a task force to advise him on implementing a midwifery program.

■

"In January 1986, the Minister announced that the government had decided to make midwifery a recognized part of the health care system in Ontario, and he appointed the task force to report to him on what shape the profession should take in the province – in effect, how they should fit in with the rest of the system. We have been studying that issue ever since. Our report is due in March 1987."

Mary Eberts
Chairperson
Task Force on Implementation of Midwifery in Ontario

The task force will determine if midwives should operate as independent practitioners or as part of an organized service. It will also examine training, professional requirements, the scope and standards of practice, the governance of the profession, the locations of practice, patient access and hospital status of midwives. Public hearings on these issues will be held in the fall of 1986.

Manpower planning

The branch monitors health manpower levels in the province, and informs the Ministry of Colleges and Universities of the need to develop or alter programs to correct imbalances and to respond to changing health care needs. One of the areas being examined is rehabilitation services. In December 1985, a detailed survey was conducted to determine the number of rehabilitation practitioners in the province and the future demand for such personnel. In addition, 500 rehabilitation students were given grants to help with their educational expenses. With Ontario faculties of medicine, a review of post-graduate training of doctors was carried out, to compare the number and type of training positions with projected needs for physicians in Ontario.

Other grants were also made in connection with training health care personnel or assessing health manpower requirements. Among them:

- $87,000 to complete a pilot project on the training of nurses for critical care;
- $41,000 to study an expanded role for nurses in neonatology.

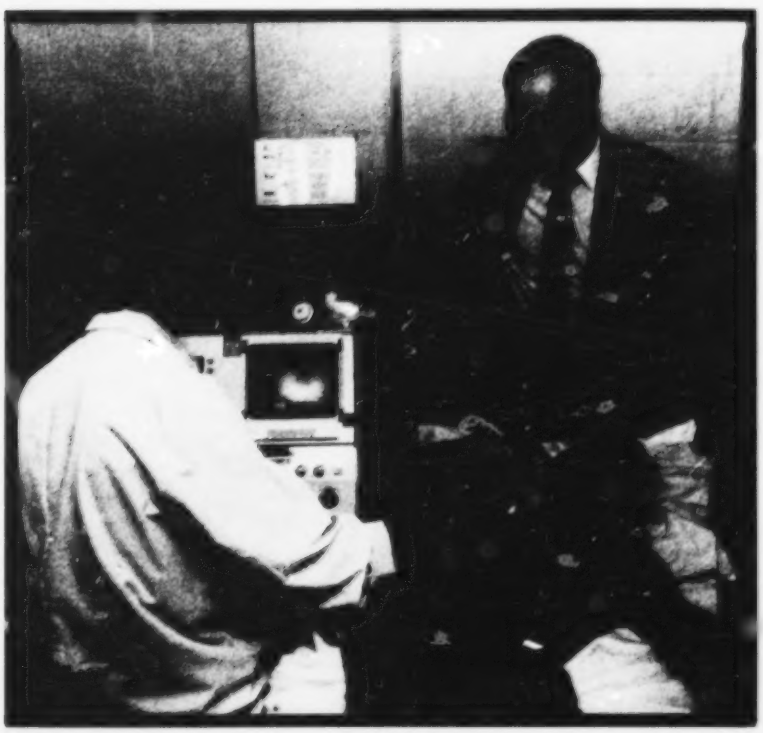
Research

In 1985/86, the ministry gave $5.7 million in grants to 99 research projects. Another $3.3 million was awarded to 66 career scientists, 17 post-doctoral fellows and 24 graduate students through the Health Research Personnel Development Program.

■

"The research we're doing involves looking at the disorder of gall stones, and how we can better predict if someone has them, on the basis of their symptoms. The result may be helpful to family physicians in screening their patients. Hopefully, what we come up with will be useful in helping them to decide if they have to go on to having ultra-sound or some other kind of examination."

Dr. Richard Birtwhistle (standing)
Researcher
Queen's University



The 99 research projects supported by the ministry included:

- an evaluation of computerized interviews in diagnosing psychiatric disorders;
- an evaluation of a geriatric day hospital which provides a full range of services to the elderly without hospitalization;
- a comparison of two types of pacemakers which will improve the treatment of cardiac patients;
- a project to determine the most reliable tests for diagnosing gall bladder disease;
- an assessment of the impact of continuing education and membership in the College of Family Physicians of Canada on the quality of primary health care.

Almost 13 per cent of the research grants were given to projects which involve health promotion, an indication of the ministry's strong interest in this field. More than $730,000 was provided for nine research projects in health promotion, including an evaluation of a school program designed to help children avoid smoking and a study of injuries incurred by amateur runners.

In addition to research grants, a one-time award from provincial lottery proceeds of $3 million was provided in 1985/86 for Ontario's five health sciences centres to purchase or upgrade equipment used in clinical research.

French Language Health Services

A significant number of initiatives have been undertaken by the Ministry of Health to support its commitment to French language health services.

The Office of the Co-ordinator for French Language Services implemented programs and provided special funding for services that help to increase the availability of French-speaking health professionals, particularly in audiology, speech pathology, physiotherapy, occupational therapy, nursing and medicine.

In 1985, the ministry embarked on a four-year campaign with the slogan: "Une carrière en santé – Ça m'intéresse" aimed at encouraging French-speaking students to pursue careers in the health disciplines. The director, a teacher herself, visits francophone and bilingual schools to inform students, their teachers, counsellors and parents of available health careers and the prerequisite courses to enter these fields of study. To date, more than 10,000 young people in 110 schools have seen the presentation. Eventually, the campaign will reach all French and bilingual schools in Ontario.

In order to achieve more immediate results in increasing the number of bilingual health professionals, the ministry funds and co-ordinates a language training program for hospital staff members who regularly care for French-speaking patients. The program provides uniform French instruction in hospitals located in areas of the province where there is a high concentration of francophones.

Studies of French language needs were conducted by consultants in 10 public hospitals in northwestern Ontario during 1985. In February 1986, the consultants presented the ministry and the hospitals with recommendations to improve the delivery of French services.

■

"I visit the intermediate schools and the French high schools or the mixed high schools all over the province. I speak about careers in the health field, because right now there is a shortage of bilingual health professionals. We can't fulfil the requirements for French health services because there aren't enough people – doctors, nurses, physiotherapists, occupational thereapists, psychologists, speech pathologists, audiologists. I visit seven or eight schools a week, and I probably talk to about 500 students. Here, I'm in Sault Ste. Marie."

Claire Séguin
Director
"Une carrière en santé – Ça m'intéresse"

Three district health councils located within designated areas have embarked on similar studies focusing on the overall language needs of the communities under their respective jurisdictions.

Two agencies offering health-related services in French to their communities received funding from the ministry. The Family and Patient Communication Centre of Ottawa Inc. provided translation and interpretation services in facilities such as hospitals, clinics, public health units and physicians' offices for residents of Ottawa and the surrounding eastern Ontario area.

In Toronto, L'Accueil Médical Francophone provides a similar service. In addition, l'Accueil assists out-of-town francophone patients and their families in finding moderately-priced lodging, helps them orient themselves to the city and has professional staff on hand to offer counselling in French.

The ministry also funds and co-ordinates the translation of programs developed by professional associations for the use of francophones. Such a program for impaired children was developed by a hospital, and the ministry arranged for its adaptation to the needs of Franco-Ontarians.

Documents and health-related educational material intended for the public are also translated at the ministry's expense and free-of-charge to hospitals, health units and other agencies providing health services and information.

Health Promotion

In response to regional conferences on the future of health care in the province and increasing evidence of public concern about healthy lifestyles, the ministry launched a major health promotion initiative late in 1984. Two key elements of this initiative were the establishment of an Office of Health Promotion as the focal point of planning within the ministry and an external advisory group to provide advice to the Minister.

The Office of Health Promotion was established in December 1984 to co-ordinate and facilitate the development and implementation of health promotion in all sectors of the province. In this first full year of operation, the office has focused on the four theme areas of smoking, fitness, nutrition, and alcohol and drug consumption. Within this context, the office has consulted to provide guidance, expertise, and data; co-ordinated ministry support of community health promotion initiatives; developed and implemented ministry project and policy initiatives; and facilitated the work of other government and non-government bodies in health promotion.

The office has, in addition, provided secretariat support to the Minister's advisory group, the Ontario Implementation Group on Health Promotion and Disease Prevention. An initial achievement of the office was the publication of the Guide to Health Promotion Programs and Materials in Ontario. The guide offers a basic reference source for health promotion programs sponsored by some 200 non-profit agencies and organizations in the province. It identifies resource materials, gives a brief program description, states the program objectives and indicates the population group which the program serves.

The Ontario Implementation Group on Health Promotion and Disease Prevention

The implementation group was established in November 1984 to develop new approaches encouraging better fitness and nutrition and discouraging smoking and excessive drinking. The group, headed by Steve Podborski, is composed of representatives from district health councils, the scientific community, physical and health education fields, alcohol and drug abuse organizations, and people active in nutrition and health promotion.

During 1985, as a starting point for planning, the implementation group focused on the need for a concrete definition or policy regarding health promotion. The group's response was the development of a mission statement for itself and a conceptual framework for all aspects of health promotion. This framework has since been the cornerstone of the group's communication with community experts and organizations around the province.

In early 1986, the implementation group convened a think-tank involving representatives from key proponents of health promotion. The purpose of the retreat was to help accelerate the pace of health promotion activity in a co-ordinated fashion.

■

"We're an advisory group that advises the Minister on current issues, and on the various concerns of the community regarding health promotion. We are a conduit to the Minister for the issues that are being raised in the community. We don't have any specific axes to grind. We advocate an ecological approach to health promotion; we don't think that any one thing is the answer. One has to take a more global approach to the promotion of good health, and we try to develop those approaches and present them in a coherent form."

Steve Podborski
Chairperson
Implementation Group on Health Promotion and Disease Prevention

Communications and Information Branch

The Communications and Information Branch provides services to both the public and the ministry itself. It helps other branches of the ministry with public education and communication programs and it helps the public get the information it wants about ministry programs.

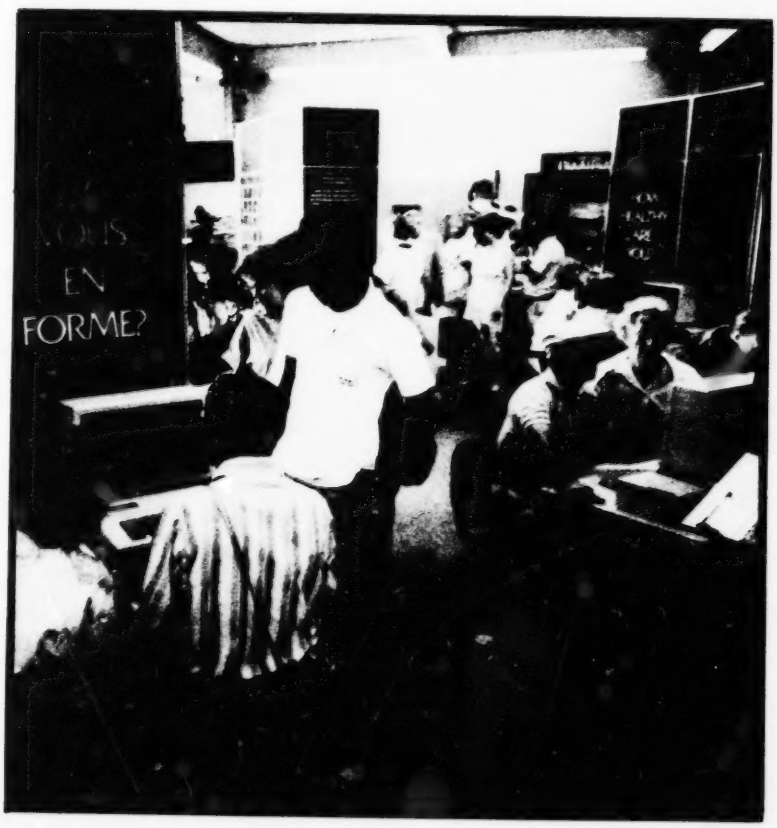
The branch produces reports, advertisements, booklets, teaching aids, and displays for exhibitions. In the past year a rabies exhibit encouraged people to vaccinate their pets, and a computer lifestyle analysis program asked – and answered – the question "How Healthy Are You?" The popular children's play "Health Spell" returned for a sixth successful tour of the province to teach eight to eleven year olds the importance of good health habits, and for the first time was presented in a French version called "La santé c'est pas sorcier".

In addition to public education programs, the branch responds to questions about health care from both the press and the public. The media relations section answers questions every day from journalists; it arranges interviews with ministry staff and issues news releases. The Health Information Centre answers questions from the public. During the fiscal year, it responded to 24,000 telephone calls and 9,500 letters from people who needed information about health care.

■

"I enjoyed working on the "How Healthy are You?" exhibit and I found out for the first time how important health is. I'm studying computer science, so I was able to help the people using the terminals and explain the questions so they could find out how healthy they are."

Danilo Servilla (standing, foreground)
Student employee
CNE exhibit, Toronto



Statement of Revenue and Expenditure – 1985/86

Expenditure	
Ministry Administration Program	
Main Office	$ 5,474,780
Financial Services	7,412,178
Supply and Office Services	12,730,103
Personnel Services	4,143,400
Information Services	4,602,436
Analysis and Planning	314,274
Legal Services	816,746
Audit Services	1,626,365
Research	22,830,967
Systems Development Services	18,686,980
Lieutenant Governor's Board of Review	907,683
Total	$ 79,545,912
Institutional Health Program	
Program Administration	$ 1,110,305
Hospitals and Related Facilities	4,874,334,284
Total	$4,875,444,589
Emergency Health Services, Laboratories and Drug Benefit Programs	
Program Administration	$ 253,255
Emergency Health Services	132,778,326
Laboratory Services	25,278,372
Drug Benefits	347,265,295
Total	$ 505,575,248
Mental Health Program	
Program Administration	$ 3,744,361
Psychiatric Services	273,938,571
Community Mental Health	168,836,861
Total	$ 446,519,793
Community and Public Health Program	
Program Administration	$ 422,499
Community Health Services	436,871,651
Public Health	131,157,251
District Health Councils	9,053,703
Total	$ 577,505,104
Health Insurance Program	$2,779,219,830
Total Expenditure	$9,263,810,476
Revenue	
Contributions:	
Government of Canada	$ 13,720,082
Premiums:	
Ontario Health Insurance Plan	1,621,705,344
Loans to Public Hospitals	10,861,563
Miscellaneous	66,062,701
Total Revenue	$1,712,349,690

Summary of OHIP Activities

April 1, 1985 to March 31,1986

Enrolment	*Certificates*	*(%)*	*Participants*	*(%)*
Average number of certificates and participants during 1985-86				
Single	2,047,330	(44.8)	2,047,330	(22.6)
Family	2,522,091	(55.2)	7,016,670	(77.4)
Total	4,569,421		9,064,000	
Groups	2,260,162	(49.5)	5,290,306	(58.4)
Full pay	485,667	(10.6)	1,011,347	(11.1)
Partially assisted	7,271	(0.2)	12,001	(0.1)
Fully assisted	355,767	(7.8)	539,219	(5.9)
Temporary assisted	93,388	(2.0)	160,063	(1.8)
65 and over	1,061,829	(23.2)	1,500,854	(16.6)
D.V.A.	23,830	(0.5)	46,220	(0.5)
Municipal welfare	117,621	(2.6)	196,309	(2.2)
Provincial welfare	163,886	(3.6)	307,681	(3.4)
Total claim payments paid during year	$2,723,699,823			
Service distribution (All payments)		*(%)*		
Medical	2,504,396,943	(92.0)		
Dental	8,678,942	(0.3)		
Optometric	48,573,643	(1.8)		
Chiropractic	59,926,448	(2.2)		
Osteopathic	327,117	(—)		
Chiropody	5,201,246	(0.2)		
Physiotherapy	17,336,155	(0.6)		
Out of Province Hospital	79,259,229	(2.9)		
Mode of payment (Based on claims payments)	*Physician %*	*Subscriber %*		
Medical	93.3	6.7		
Dental	93.7	6.3		
Optometric	98.1	1.9		
Chiropractic	98.5	1.5		
Osteopathy	94.7	5.3		
Chiropody	94.7	5.3		
Physiotherapy	100.0	—		
Overall	93.6	6.4		
Revenue				
Net premium revenue for combined plan $1,621,705,344				

Ontario Drug Benefit Plan

April 1, 1985 to March 31,1986

1. Expenditures	
Health	$344,386,361.33
COMSOC	$ 68,977,335.65
Expenditure Recovery	($27,905.88)
Plan Total	$413,335,791.10

2. Eligible Persons

Group	Eligible Persons	Actual Recipients
OAS (Over 65)	1,004,849	870,809
Home Care	18,284	18,284
Other Institutional Care	14,197	14,197
General Welfare	228,861	228,861
Family Benefits	254,270	247,962
Totals	1,520,461	1,380,113

3. Claims Paid	
Number of Regular Claims	28,285,000
Number of Special Claims	1,741,000
Total Number of ODB Claims	30,026,000
4. Average Price Paid per "Fee for Service" Claim	$13.15
Average Dispensing Fee	$ 4.97
Average Drug Cost	$ 8.76

Ministry of Health
Ontario
Murray J. Elston, Minister
Allan Dyer, Deputy Minister

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